MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC

Requestor's Name and Address SURGICAL AND DIAGNOSTIC CENTER 729 Bedford-Euless Rd. West, Suite 100 Hurst, TX 76053	MDR Tracking No.: M4-04-4692-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address **Rep Box 28** LIBERTY MUTUAL FIRE INSURANCE c/o Hammerman & Gainer	Date of Injury: Employer's Name: Nestle Waters North American Insurance Carrier's No.: 949722979

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03-13-03	03-13-03	**25260** Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	$3,281.41	$1,443.21
03-13-03	03-13-03	**93005** Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	$35.00	$0.00
03-13-03	03-13-03	**93010** Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	$2.25	$0.00
			Total Amount Paid:	**(-$1,260.00)**
			Remainder Due:	**$183.21**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor's Rationale for increased reimbursement or refund as indicated on the TWCC-60 states, "Our charges are fair and reasonable based on other insurance companies determination of fair and reasonable payments of 85% - 100% of our billed charges. Workers' Compensation carriers are subject to a duty of good faith and fair dealings in the process of workers' compensation claims."

In letter dated 12-24-03 Requestor stated, "…Surgical and Diagnostic Center contends that the fee paid was not fair and reasonable because it is below the amount the majority of other insurance carriers are reimbursing and does not take into account all of the supplies and medications to treat this patient, the amount of time spent in the procedure room/operating room, and other costs. The fee paid does not ensure the quality of medical care because we were not adequately reimbursed for the combination of items that was used for this patient. The fee paid does not ensure effective medical cost control because it does not properly compensate for items specifically needed by and provided to the patient… We feel that Liberty Mutual has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85% - 100% of our billed charges…"

PART IV: RESPONDENT'S POSITION SUMMARY

Alternate TWCC-62 EOB submitted indicated $1260.00 paid on 4-22-03 with codes: Z601 – The charge exceeds usual and customary; Z652 – Recommendation of payment has been based on a procedure code, which best describes services rendered and X094 – Charges, included in the facility fee.

In letter dated 01-09-04 from Carrier stated, "Liberty Mutual believes that the reimbursement made to the provider is considered to be "fair and reasonable" and that they are in compliance with the TWCC rules and regulations. Liberty Mutual does not

believe Surgical and Diagnostic Center is due any further reimbursement for services rendered to Enkar Prado for date of service 3/13/03."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that neither party has provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement (Rule 133.307). After reviewing the services, the charges, and both parties' positions, it is clearly evident that some other amount represents the fair and reasonable reimbursement.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 192.6% to 256.3% of Medicare for this particular year-2003). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, staff selected a reimbursement amount in the mid range of the Ingenix range. Additionally, based on CMS ASC guidelines, lab fees and diagnostic or therapeutic items or services are included in the facility fees and are not separately payable. The total amount was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommended amount, discussed the facts of the individual case, and selected the appropriate "fair and reasonable" amount to be ordered in the final decision.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that the fair and reasonable reimbursement amount for these services is $1,443.21. Since the insurance carrier paid a total of $1,260.00 for these services, the health care provider is entitled to an additional reimbursement in the amount of **$183.21.**

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$183.21.** The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

		08/11/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____